State of California
Respiratory Care Board
444 North 3rd Street, Suite 270
Sacramento, CA 95814
Telephone (916) 323-9983
Fax (916) 323-9999
www.rcb.ca.gov

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Inquiry: I have a question regarding limited staffing at a hospital that requires RCP's to triage patient treatments. I work for a hospital that has decided a specific number of RCP's will be used in the facility regardless of the number of patients that have procedures ordered. In the past each procedure was given a procedure count. Then based on the number of procedures counted for the day a specific number of therapists were assigned to meet the needs of the facility at a safe staffing level. However recently a new VP has been trying to cut costs and save the hospital money. I will also mention that this VP has no medical background and really does not understand our role in the hospital. He has decided that the maximum number of RCP's in the hospital for any shift is going to be 7, when normally we may have needed to run 8, 9, or 10 RCP's. To give you an idea of our hospital we are roughly 300 beds with 3 adult ICU's, 1 NICU, a very busy ER, and the rest floor beds. This is where my question comes in. Now that this VP has mandated the number of RCP's we have to triage patient treatments. Not just 1 or 2, but patients that are in the hospital for acute pulmonary conditions with treatment orders of Q4 are lucky to see an RCP once in 12 hours. And the number of treatments being missed per day may be as high as 20 or more. My fellow RCP's and I in this facility are concerned because the winter season is just getting started and it places a great deal of pressure on the RCP to have to make the decision about who should get their ordered treatments and who can be missed. I also must state that we get many complaints from our patients, the doctors, the nurses, and the RCP is left apologizing to everybody. We believe that by the time the winter season hits in full force the RCP's will be triaging most if not all floor patients to deal with critical care units. The treatments that are going to be missed will probably reach 30-40 + on some days and the patients are going to suffer as a result. If the hospital would just return to counting procedures and staffing accordingly we would have to staff to provide safe therapy to all patients. Is this an issue for the Respiratory Care Board of California or should I be writing to another government agency for advice.

Response: As you know, your complaint was forwarded to the Department of Health Services (DHS) on or about January 11, 2004. Our office continues to follow up with the DHS evaluator handling the case to ensure that your concerns are investigated and appropriate care is being provided. Your inquiry was also forwarded to the Board's Professional Licensing Committee who had these comments as it relates to staffing:

> Your question regarding appropriate staffing is a good one and has come before the Board before. From a staffing perspective, the Board does endorse the current American Association for Respiratory Care criteria for staffing guidelines. However, the Board does not have any guidelines or staffing ratios in place that deal with your question at hand. DHS and JCAHO, however, both have specific guidelines that address this issue of staffing and its relationship to your organization. The following are some excerpts from both the JCAHO and DHS (Title 22) that is specific to staffing:
>
> <u>JCAHO</u>

LD.2.4 Directors recommend a sufficient number of qualified and competent persons to provide care.

HR 2.1 The organization uses data on clinical/ service screening indicators in combination with human resource screening indicators to assess staffing effectiveness.

Examples Given:

Each department must select at least 4 clinical indicators and compare to human resource indicators to determine if there is a correlation between the two. One example might be pneumonia compared to staff vacancy rate or pneumonia to staff turn over rate.

Indicators are:

Overtime, staff vacancy rate, staff satisfaction, staff turnover rate, understaffing as compared to organization's staffing plan, nursing care hours per patient day, staff injuries on the job, on-call or per diem use, sick time, family complaints, patient complaints, patient falls, adverse drug event, injuries to patients, skin breakdown, pneumonia, postoperative infections, urinary tract infection, upper gastrointestinal bleeding, shock/cardiac arrest, length of stay.

DHS
Title 22 Regulation references 70403, 70405, 70615, 70617 and 70619. There are also many medical groups that support the use of respiratory care practitioners but do not address staffing specifically. These groups include the American Thorasic Society, American Society of Anesthesia, California Thorasic Society to name a few. These letters of support can be accessed from the AARC web site or by calling them directly.

Board staff will continue to follow the handling of your complaint to ensure patients are receiving proper care. If you have any additional questions or concerns please do not hesitate to contact Stephanie Nunez, Executive Officer at the Respiratory Care Board office.

Reference # 2003-C-34